FENWAY HEALTH

The information in your medical record is confidential and is protected under Massachusetts General Laws Ch. 111, Sec 70. Your written consent will be required for release of information except in the case of a court order.

Medical Record #
(For office use only)

Patient Registration- Minor

Child's Legal Name* Last First Middle Initial **Child's Name used:**

Child's Legal Sex (please check one)* ☐ Female ☐ Male
**While Fenway recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.*

Child's Pronouns used:

Child's Date of Birth *Month Day Year* / /

Child's Social Security #

Child's State ID # or License # (if applicable)

For patients under 18, the Department of Public Health requires that we obtain parent/guardian contact information:
Parent/Guardian Name Date of Birth Relationship to child Phone Number

Other Parent/Guardian Name Date of Birth Relationship to child Phone Number

Parent/Guardian Occupation Employer/School Name Is child covered under school or employer insurance?
☐ Yes ☐ No

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone
( )
Ok to leave voicemail?
☐ Yes ☐ No

Cell Phone (check whose phone)
☐ Child ☐ Parent/Guardian
( )
Ok to leave voicemail? ☐ Yes ☐ No

Work Phone (check whose phone)
☐ Child ☐ Parent/Guardian
( )
Ok to leave voicemail? ☐ Yes ☐ No

Best number to use:
☐ Home ☐ Cell
☐ Work

Address City State ZIP

For Patients aged 12 and older: Patient's own Email address: _____

For Patients below the age of 12: Parent/Guardian Email address: _____

***Fenway Health will send certain correspondence, such as bills, to your mailing address*. How would you prefer to receive other types of written correspondence? (check one)** ☐ Secure Email (MyFenway) ☐ Letter ☐ Other

Please complete the following demographic information. It is for demographic purposes only and will not affect care.

1.) Annual income for patient's household?

_____

❑ No income

1a.) How many people (including patient) does this income support?

_____

2.) Employment Status

❑ Employed full time
❑ Employed part time
❑ Student full time
❑ Student part time
❑ Retired
❑ Not working
❑ Other _____

3.) Racial Group(s)
(check all that apply)

❑ African American / Black
❑ Asian
❑ Caucasian / White
❑ Native American / Alaskan Native / Inuit
❑ Pacific Islander
❑ Other _____

4.) Ethnicity
❑ Hispanic/Latino/Latina
❑ Not Hispanic/Latino/Latina

5) Country of Birth
❑ USA
❑ Other _____

6.) Patient's Preferred Language (choose one:)

❑ English
❑ Español
❑ Français
❑ Português
❑ Русский
Other: _____

7.) Referral Source
❑ Self
❑ Friend or Family Member
❑ Health Provider
❑ Emergency Room
❑ Ad/Internet/ Media Outreach
❑ Work or School
❑ Other:_____

8.) Patient's Marital Status
❑ Married
❑ Partnered
❑ Single
❑ Divorced
❑ Other_____

9.) Patient's Veteran Status
❑ Veteran
❑ Not a Veteran

10.) *(patients over 12 only):*
Does patient think of self as:
❑ Lesbian, gay, or homosexual
❑ Straight or heterosexual
❑ Bisexual
❑ Something else
❑ Don't know

11.) What is the patient's gender?
☐ Female
☐ Male
☐ Genderqueer or not exclusively male or female

12.) What was the patient's sex assigned at birth?
☐ Female
☐ Male

13.) Does the patient identify as transgender or transsexual?
☐ Yes
☐ No
☐ Don't know